ARIZONA STATE VETERINARY MEDICAL EXAMINING BOARD

1740 W. ADAMS ST., SUITE 4600, PHOENIX, ARIZONA 85007
PHONE (602) 364-1PET (1738) FAX (602) 364-1039
VETBOARD.AZ.GOV

COMPLAINT INVESTIGATION FORM

If there is an issue with more than one veterinarian please file a separate Complaint Investigation Form for each veterinarian

PLEASE PRINT OR TYPE

FOR OFFICE USE ONLY

Date Received: April 13, 2020 Case Number: 20-99

A. THIS COMPLAINT IS FILED AGAINST THE FOLLOWING:

Name of Veterinarian/CVT: Palm Glen Animal Hospital

Premise Name: Melisa and Dr. Mangone

Premise Address: 7771 N. 43rd

City: Phoenix State: AZ Zip Code: 85051

Telephone: (602) 841-12-00

B. INFORMATION REGARDING THE INDIVIDUAL FILING COMPLAINT*:

Name: Aaron Barraza

Address: [redacted]

City: [redacted] State: [redacted] Zip Code: [redacted]

Home Telephone: [redacted] Cell Telephone: [redacted]

**STATE LAW REQUIRES WE HAVE TO DISCLOSE YOUR NAME UNLESS WE CAN SHOW THAT DISCLOSURE WILL RESULT IN SUBSTANTIAL HARM TO YOU, SOMEONE ELSE OR THE PUBLIC PER A.R.S. § 41-1010. IF YOU HAVE REASON TO BELIEVE THAT SUBSTANTIAL HARM WILL RESULT IN DISCLOSURE OF YOUR NAME PLEASE PROVIDE COPIES OF RESTRAINING ORDERS OR OTHER DOCUMENTATION.*

C. PATIENT INFORMATION (1):

Name: Bambam

Breed/Species: rottweiler

Age: 3 m Sex: Male Color: Black/Brown

PATIENT INFORMATION (2):

Name: _____

Breed/Species: _____

Age: _____ Sex: _____ Color: _____

D. VETERINARIANS WHO HAVE PROVIDED CARE TO THIS PET FOR THIS ISSUE:

Please provide the name, address and phone number for each veterinarian.

Tender, Loving care. Phone 480-699-9950

600 W. Broadway Rd.

* When Bambam got worse we took him here.

* Saw the Puppy die.

E. WITNESS INFORMATION:

Please provide the name, address and phone number of each witness that has direct knowledge regarding this case.

Alfonso Barraza

Phone [redacted]

Adress [redacted]

Attestation of Person Requesting Investigation

By signing this form, I declare that the information contained herein is true and accurate to the best of my knowledge. Further, I authorize the release of any and all medical records or information necessary to complete the investigation of this case.

Signature: Alfonso Barraza

Date: 4-6-2020

RECEIVED
APR 13 2020
BY:

F. ALLEGATIONS and/or CONCERNS:

Please provide all information that you feel is relevant to the complaint. This portion must be either typewritten or clearly printed in ink.

We paid for a veterinarian not for a Veterinary Technician to see our sick puppy. The only interaction I had with the veterinarian only lasted 30 sec which he told me that the puppy tested for Parvo was positive.The veterinarian(Dr. Mangone) then gave me two option inhouse and house treatment . Never did he see or opened the car door to physically see the dog. After that i never saw or heard from him.

The Veterinary Technician did everything. She(Melsia) did the extraction for the pavo test, inserted the fluids(subcutaneous) , cefovecin (convenia) , maropitant(cerenia) and gave me a recipe for the wet dog to buy, If though the puppy was throwing up any food he was eating which i told her when I was filling up the paper work. I even told her what other treatments were available for the puppy but she assured me that the treatment that they gave me was the best one. Even though I was adamant about other treatments and still had many question about the health of my puppy she quickly left due to a emergency of another customer.

20-99 mangone

Bam Bam was presented to Palm Glen with a history of vomiting, diarrhea, and lethargy for a few days. As per protocol, Bam Bam was triaged by the assistant and, because of the clinical signs, a parvo test was run.

The Parvo test was a strong positive. I went outside to speak with the person presenting Bam Bam and spoke at length about the positive test and what that means. I also spoke with him about in patient VS outpatient treatment and the parent survival rates between the two (something around 90% vs 60% at PG).

At this point I told the person presenting Bam Bam I would be back out after putting together a couple of estimates and since I had not grabbed the appropriate PPE to examine a dog with Parvo as I am used to it being inside or just outside the rooms.

Melissa went outside to present the estimates and, after the presenter called someone to discuss the estimates, informed me that the outpatient estimate was chosen. I instructed her to get the fluids and medications together and to get started and that I would be out when I finished with the next case. Melissa also said that the person presenting Bam Bam asked what to feed him if he would eat and we decided that he should try A/D, I/D, or a home cooked bland diet if there appeared to be interest.

About 30-45 minutes after the above conversation I realized that I had yet to get back out to examine Bam Bam and finalize my conversation with the person with him. At that time, i was informed that he had left with Bam Bam.

When I stopped into work the next day I was informed that Bam Bam's owner had called and had been told to come back in immediately by Maren. Later that day Maria informed me of her conversation with the actual owner of Bam Bam.

20-99 mangone

Bam Bam came to Palm Glen on one of the first days of the curbside/social distancing implementation and was the first dog with parvovirus that was seen. We thought we had appropriate protocols in place but obviously, we did not and we failed Bam Bam and the owner in the mild chaos of the chage.

We should have brought Bam Bam into the hospital regardless of the owner's choice of care and have changed our protocol to reflect this. This is my failure. In trying to decrease contamination I failed to address the patient needs first

I normally rely on the light and flag system that we have in the hospital to continuously remind myself which rooms are active and who still needs to be seen. In this case I became side tracked with other cases because Bam Bam was not in the hospital and did not get back out to see him before he left.

Once I realized that Bam Bam had been taken home I should have called to have the owner return bit I did not do so.

Because of the contamination and the, at the time, new curbside policy the triage notes that would normally be entered in the infectious room were not entered into the computer.

In short, because of the protocols I put in place I did not provide the level of care that I should have.

Berney Mangone, DVM.

DOUGLAS A. DUCEY
- GOVERNOR -

VICTORIA WHITMORE
- EXECUTIVE DIRECTOR -

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INVESTIGATIVE COMMITTEE REPORT

TO: Arizona State Veterinary Medical Examining Board

FROM: PM Investigative Committee: Adam Almaraz - Chair
Amrit Rai, DVM
Cameron Dow, DVM
William Hamilton
Brian Sidaway, DVM

STAFF PRESENT: Tracy A. Riendeau, CVT – Investigations
Marc Harris – Assistant Attorney General

RE: Case: 20-99
Complainant(s): Aaron Barraza
Respondent(s): Bernard Mangone, DVM (License: 3371)

SUMMARY:
Complaint Received at Board Office: 4/13/20
Committee Discussion: 9/1/20
Board IIR: 10/21/20

APPLICABLE STATUTES AND RULES:
Laws as Amended August 2018 (Lime Green); Rules as Revised September 2013 (Yellow)

On April 3, 2020, "Bambam," a 3-month-old male Rottweiler was presented to Respondent due to vomiting and having diarrhea. Due to COVID-19 precautions technical staff triaged the dog curbside and performed a parvo test based on the dog's symptoms.

The parvo test was positive therefore Respondent went to the car to discuss treatment options with the pet owner – inpatient vs outpatient. Staff presented estimates to the pet owner, who chose outpatient treatment for the dog.

Respondent instructed technical staff to treat the dog with fluids and medications while he finished the case he was working on. The pet owner left before Respondent had an opportunity to speak with them again.

The following day the dog passed away.

Complainant was noticed and appeared telephonically.
Respondent was noticed and appeared telephonically.

The Committee reviewed medical records, testimony, and other documentation as described below:

- Complainant(s) narrative: *Aaron Barraza*
- Respondent(s) narrative/medical record: *Bernard Mangone, DVM*
- Consulting Veterinarian(s) narrative/medical records: *Tender Loving Care; Dr. Wooton and Christian DeHaven.*

PROPOSED 'FINDINGS of FACT':

1. On April 3, 2020, the dog was presented to Respondent's premises due to vomiting and having diarrhea. Due COVID-19 the dog was triaged curbside by technical staff; based on symptoms, a parvo test was performed and was a strong positive.

2. According to Respondent, he went to the car to speak with the pet owner (presumed). He discussed, at length, about the positive parvo test, what that meant and treatment options – inpatient vs outpatient treatment – and their survival rates. Respondent explained that he would put together estimates for treatment and would return with the appropriate PPE to examine a patient with parvo.

3. Technical staff returned to the pet owner's car to present the estimates and outpatient treatment was selected. Respondent instructed staff to get the outpatient treatment started with fluids and medications while he finished the case he was dealing with. Technical staff treated the dog with:

a. SQ fluids (type and amount unknown);
b. Maropitant 10mg/mL, 1.60 (mLs? Route unknown); and
c. Cefovecin 80mg/mL, 1.60 (mLs? Route unknown).

4. The pet owner was given fluids to administer at home (instructed to give 500mLs SQ the next day); amount and type dispensed unknown. Additionally, Maropitant 60mg, give one tablet orally every 24 hours, was dispensed; amount unknown. To get the dog to eat, a/d was also dispensed.

5. According to Respondent, a short time later he realized that he had not yet gone back out to examine the dog and finalize his conversation with the pet owner. He was advised that the pet owner had left. The dog was never examined (screenshot of the computer stated the dog weighed 32 pounds); Respondent did not call the pet owner to finish his conversation with them regarding the care of the dog.

6. The following day, the pet owner called to report that the dog was still having diarrhea; fluids were administered and the dog did not want to eat. Hospital staff recommended bringing the dog back for hospitalization – pet owner stated they would call back shortly if they wanted to hospitalize the dog.

7. Later that day, the pet owner visited Tender Loving Care Veterinary Services at Gordon's Feed without the dog. Mr. DeHaven greeted the pet owner and they discussed the dog's history. Mr. DeHaven recommended returning the dog to Respondent for care.

8. Approximately 30 minutes later the pet owner returned to Tender Loving Care Veterinary

Services at Gordon's Feed with the dog in the back seat of his vehicle, asking if they could look at the dog. Ms. DeHaven said they could and looked into the vehicle at the dog; the dog appeared lifeless and she called for the veterinarian. Dr. Wooton immediately went to the vehicle to find the dog had passed away.

COMMITTEE DISCUSSION:

The Committee discussed there were clearly medical record concerns. They understood that the pandemic has caused issues and the need to make adjustments in practice in these times. However, the Committee felt that once Respondent realized he did not speak with the pet owner, he could have called him that evening to follow up. The following day, Respondent had another opportunity to follow up.

Additionally, Respondent had many medical record omissions -- if Respondent forgot entries due to the pandemic related issues, he could have noted that in the medical record.

The Committee discussed that Respondent did not have conversations with the pet owner about how serious parvo is in the Rottweiler breed. The Committee also questioned if the weight was correct on the puppy. They did not have issues with the treatment options offered to Complainant, although euthanasia could have been an option.

COMMITTEE'S PROPOSED CONCLUSIONS of LAW:

The Committee concluded that possible violations of the *Veterinary Practice Act* occurred.

COMMITTEE'S RECOMMENDED DISPOSITION:

Motion: It was moved and seconded the Board find:

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (L):

- *(4) failure to perform an exam on the puppy including a temperature, heart rate, respiration rate, and general condition of the animal and document it in the medical record;*
- *(7), (7) (b), and (7) (d) failure to document in the name, amount and route of administration of fluid administered to the puppy;*
- *(7) (d) failure to document in the medical records the route of administration of cerenia and covenia administered to the puppy; and*
- *(8) failure to document the name, amount and frequency of fluids prescribed to the puppy.*

Vote: The motion was approved with a vote of 5 to 0.

The information contained in this report was obtained from the case file, which includes the complaint, the respondent's response, any consulting veterinarian or witness input, and any other sources used to gather information for the investigation.

DOUGLAS A. DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

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CERTIFIED MAIL
9489009000276265240782

October 26, 2020

Bernard Mangone, DVM
ADDRESS ON FILE

LETTER OF CONCERN – 20-99 - In Re: Bernard Mangone, DVM

Dear Dr. Mangone:

At its meeting on October 21, 2020, the Arizona State Veterinary Medical Examining Board considered information presented in the complaint case opened by the Board regarding a complaint filed by Mr. Aaron Barraza.

In each case, the Board considers the situation and the professional's response, as well as all relevant information. In this matter, after review and discussion, the Board voted to issue you a Letter of Concern pursuant to A.R.S. § 32-2234(D). This Letter of Concern is regarding the need to ensure that all animals' medical records are properly completed.

A Letter of Concern is defined in A.R.S. § 32-2201(12) as "...an advisory letter to notify a veterinarian that, while there is insufficient evidence to support disciplinary action about certain aspects of the case, the Board believes the veterinarian should modify or eliminate certain practices and that continuation of the activities that led to the information being submitted to the Board may result in action against the veterinarian's license."

We hope you will take this advisory letter in the spirit that it is intended to avoid any other potential violations in the future.

Respectfully,
FOR THE BOARD

V. Whitmore

Victoria Whitmore
Executive Director

cc: Aaron Barraza

DOUGLAS A. DUCEY
GOVERNOR

VICTORIA WHITMORE
EXECUTIVE DIRECTOR

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IN ACCORDANCE WITH A.R.S. § 32-2237(D): "IF THE BOARD REJECTS ANY RECOMMENDATION CONTAINED IN A REPORT OF THE INVESTIGATIVE COMMITTEE, IT SHALL DOCUMENT THE REASONS FOR ITS DECISION IN WRITING."

At the October 21, 2020 meeting of the Arizona State Veterinary Medical Examining Board, the Board considered the recommendations of the Investigative Committee in regards to case number 20-99 In Re: Bernard Mangone, DVM.

The Board considered the Investigative Committee's Findings of Fact and Conclusions of Law:

ARS § 32-2232 (21) as it relates to AAC R3-11-502 (L):

- *(4) failure to perform an exam on the puppy including a temperature, heart rate, respiration rate, and general condition of the animal and document it in the medical record;*
- *(7), (7) (b) and (7) (d) failure to document in the name, amount and route of administration of fluid administered to the puppy;*
- *(7) (d) failure to document in the medical records the route of administration of cerenia and covenia administered to the puppy; and*
- *(8) failure to document the name, amount and frequency of fluids prescribed to the puppy.*

Following discussion, the Board concluded that the recommended violations did not affect the care and treatment of the dog and voted to dismiss this issue with no violation and issue a Letter of Concern with respect to ensuring medical records are completed.

Respectfully submitted this 18TH day of November, 2020.

Arizona State Veterinary Medical Examining Board

Jim Loughead, Chair